Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL EDGE HEALTHCARE GROUP
PO BOX 650268
DALLAS TX 75265

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-1650-01

MFDR Date Received
December 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Workers comp carrier, Zurich Insurance never sent us a payment, nor a denial."

Amount in Dispute: $189.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for medical treatment the requestor provided to the claimant on February 1, 2010. The requestor billed $1075 for the services rendered, and submits that it is entitled to reimbursement in the amount of $189.03. The requestor submits that the carrier has never responded to any medical bills and has not produced any EOB's. The carrier has no record of receiving a medical bill for this date of service. The requestor has failed to provide convincing evidence for the carrier's receipt of a request for an EOB. All fee reductions, if any, have been made in accordance with the applicable fee guidelines."

Response Submitted by: Zurich American Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2010	72141	$189.03	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. Neither party provided copies of EOBs relevant to the fee dispute for date of service February 1, 2010.

Issue

1. Did the requestor submit the dispute pursuant to 28 Texas Administrative Code §133.307?

Findings

1. The requestor identified on the table of disputed services, CPT code 72141 rendered on February 1, 2010. The Medical Fee Dispute Resolution (MFDR) section received the DWC060 request on December 16, 2010; therefore the dispute was submitted timely and eligible for MFDR review.

   Former 28 Texas Administrative Code §133.307(c) (2) (B), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (B).

   Former 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of medical records specific to the dates of service in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (E).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement including "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (F) (i).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not explained the reasons that the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (F) (ii).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issues including "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (F) (iii).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (F) (iv).

   As a result, for the reasons stated above, reimbursement for the disputed CPT code 72141 rendered on February 1, 2010 cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. As a result, the amount ordered is $0.00.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.